

Healthy Ageing Strategy

E noho ora ana te hunga pakeke, e noho pai ana i ngā tau o te kaumātuatanga tae noa atu ki ngā tau whakamutunga o te rangatira i roto i nga ringa manaaki, ringa atawhai o te hāpori.

Older people live well, age well and have a respectful end of life in age-friendly communities.

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Foreword

Associate Minister of Health

Older New Zealanders are a large and growing proportion of our population – by 2036, one in four of us will be aged 65 years or older. We all deserve our best support to age well, live healthy, independent lives and to have a respectful end of life.



I commissioned this revision of the Health of Older People Strategy to help ensure that the resources of our health system remain focused on providing that support and empowering people. It sets the direction for the health sector and outlines the actions needed to improve the health outcomes and independence of older people in a sustainable way.

I have rebranded it the Healthy Ageing Strategy for several reasons. We are all ageing, in different ways, and don't necessarily become 'old' when we reach the age of 65. Healthy ageing recognises the diversity of older people, and ultimately seeks to maximise health and wellbeing into and throughout people's older years.

The Healthy Ageing Strategy is aligned with the wider New Zealand Health Strategy. It also has strong links the Positive Ageing Strategy. Older people make a significant contribution to and have an integral role in our society. The

Government is committed to the goals of positive ageing, where older people age well and are healthy, connected, independent and respected.

At its heart, the Healthy Ageing Strategy is about people. Its priority is adding life to years not just years to life. People age in different ways, and our population is diverse. We must recognise the range of ways older people access and interact with services.

We need a multi-faceted and coordinated approach to improve the health and wellbeing of our older people, particularly those living with long-term conditions, with high and complex needs or in population groups that are experiencing poorer outcomes from our health system. Our health system also needs to meet the health and support needs of an increasingly ethnically diverse population.

This will require the health and social sectors to work collaboratively and for everyone in New Zealand to recognise the important role that family and whānau carers play in supporting our older people in their homes and communities.

As well as enabling and supporting older people to age well, this Strategy focuses on ensuring older people have a respectful end of life. Older people need to feel safe and supported to openly discuss and plan their end-of-life care. The health system needs to be responsive to older people's wishes.

Many people and organisations have been involved in developing this Strategy. This reflects the wide variety of those who care about and influence older people's health and wellbeing. I would like to thank everyone who has contributed.

I would especially like to acknowledge the input of older people and their family and whānau carers. Your contribution has been particularly important in helping shape the Strategy and the services it provides.

Hon Peseta Sam Lotu-liga
Associate Minister of Health

Foreword

Director-General of Health

With the release of the New Zealand Health Strategy, now is the right time to set out a refreshed strategy for the health of older New Zealanders – the Healthy Ageing Strategy.



Its predecessor, the Health of Older People Strategy, was launched in 2002. The 2002 strategy delivered many successes, including greater choice in long-term health care services. We can all be proud of that.

However, the social and demographic picture in our country has changed over the past 14 years. In 2002, when the current strategy was published, those aged over 65 made up 11.5 percent of the New Zealand population. That amount has now climbed to 15 percent and is set to climb further. This has significant implications for policy, planning, service design and delivery.

We must ensure our health system provides the care, support and treatment that older New Zealanders need and that level of care is sustainable. We want a health system that works for every older New Zealander.

Achieving this means taking into account all the factors that impact on

peoples' health and wellbeing in later life.

The Healthy Ageing Strategy has been written with this goal in mind. It has a strong focus on prevention, wellness and support for independence. It also recognises the importance of family, whānau and community in older people's lives. It gives greater priority to equity and supporting the most vulnerable, including those with high and complex needs and in the final stages of life. In addition, it signals the need for government agencies, health care providers and all who seek to make a positive difference to health and wellbeing to work together. Better integrating health and social responses will help us to be more responsive to New Zealanders' needs and choices.

The five New Zealand Health Strategy themes support the Healthy Ageing Strategy actions. These themes – people powered, closer to home, value and high performance, one

team and smart system – articulate the wider system in which the goals of the Healthy Ageing Strategy can be achieved.

I believe this strategy provides us with a clear focus and vision for where we need to head. As with the New Zealand Health Strategy, the Ministry of Health will provide the leadership needed to help all the organisations involved play their part in the required actions, changes and focus.

Leadership in this context is not about being in charge or having all the answers. Many people and organisations

were involved in creating this strategy: from individuals to families and whānau, carers, health professionals, service providers, government and non-governmental organisations. We all have an ongoing role to play in helping every older New Zealander live well, get well and stay well.

I'd like to thank everyone who has contributed to the Healthy Ageing Strategy. I look forward to working with you as we deliver it.

Chai Chuah
Director-General of Health

Contents

Foreword Associate Minister of Health	iii
Foreword Director-General of Health	v
Acknowledgements	viii
Why a Healthy Ageing Strategy	1
Strategic context	4
Taking a life-course approach	8
Challenges and opportunities	10
Vision and priorities for action	16
Ageing well – Te pai o ngātau o te kaumātuatanga	18
Acute and restorative care – Ngātuāhukatanga manaaki, whakaora i te hunga māuiui	25
Living well with long-term conditions – E noho ora ana i roto i ngā mauiuitanga o te tinana	32
Support for people with high and complex needs – He tautoko i te hunga pakeke he uaua, he maha hoki o rātau taumahatanga	37
Respectful end of life – Te mate rangatira i ngātau whakamutunga o te hunga pakeke	41
Turning the Strategy into action	45
Action plan	48
References	68

Acknowledgements

The Ministry of Health has received valuable input from over 200 written submissions on the draft Health of Older People Strategy (now Healthy Ageing Strategy) by the closing date of 7 September 2016. Five regional workshops also collected input from hundreds of participants around the country, including researchers, district health boards, clinicians, primary health and other non-governmental organisations, older people, carers, and aged-care, Māori and Pacific providers.

Earlier rounds of engagement workshops had provided a high degree of confidence around the overall approach and themes of the draft Strategy. The public consultation process on the draft focussed largely on identifying whether the right actions had been developed and given priority. Over 2000 people were involved in those Strategy development workshops.

The Ministry would like to particularly acknowledge the contribution of the expert advisory group:

- Dr Janice Wilson, Chief Executive, Health Quality and Safety Commission (Chair)
- Dr Michal Boyd, Senior Lecturer, School of Nursing and Department of Geriatric Medicine, University of Auckland
- Stephanie Clare, Chief Executive, Age Concern New Zealand
- John Collyns, Executive Director, Retirement Villages Association
- Hamish Crooks, Chief Executive, Pacific Homecare
- Dr Ken Greer, Clinical Advisor, Primary and Integrated Care, Capital and Coast District Health Board
- Vui Mark Goshe, Chief Executive, Vaka Tautua
- Julie Haggie, Chief Executive, Home and Community Health Association
- Sir Matiu Rei, Director, Ora Toa
- Robyn Scott, immediate past Chief Executive, Age Concern New Zealand
- Simon Wallace, Chief Executive, New Zealand Aged Care Association
- Sarah Clark, Director, Office for Seniors (ex-officio member)
- Blair McCarthy, Acting Director, Office for Seniors (ex-officio member).

Why a Healthy Ageing Strategy

Everyone is ageing, and everyone wants to age well. That New Zealanders are living longer than ever before is a major success story, and many older New Zealanders are healthy, active and resilient.



Remaining in good health, ageing well and being able and supported to live well with long-term conditions, however complex, is critical to enable older people to continue participating and feeling valued (two important factors for health and wellbeing).

We have a good base to build on, with many significant improvements to the health and disability support system for older people since the release of the 2002 Health of Older People Strategy. For example, we are supporting more people than ever with long-term health conditions and disabilities to remain in their homes for longer. We also provide more consistent and comprehensive needs assessments, greater choice and improvements in the quality of home and community services and aged residential care. Moreover, access to elective surgery has improved, as have discharge practices.

We want to maintain the positive changes we've seen over the last 14 years and improve on them in the current context. Our operating environment and the strategic context in which we work have changed. We need a new strategy that expands on the strengths of the past and sets the direction for improved performance and outcomes across the board.

The Healthy Ageing Strategy (the Strategy) is for older people, their families and their communities. Older people are by no means a homogenous population group. We don't become

'old' at any particular age or in the same way. Ageing is only partially associated with chronological ageing and it does not 'start' at 65. Some older people remain independent and competent, both physically and mentally, throughout their older years. Some enter their older years with long-term or chronic health conditions or disabilities, and their needs become more complex as they age. Others develop disabilities and become dependent as they age, due to cognitive and physical decline, and conditions such as dementia.

We need to ensure our system is truly people-centred and appropriate to New Zealand's growing ethnic diversity.

Our system and services must aim to keep people in good health for longer, recognising that older people have different needs at different times.

People with the highest needs may be those who have the fewest resources and the least capacity to address those needs.

This document sets out a strategy for the health and wellbeing of older people for the next 10 years.

It is the result of extensive engagement with older people, their families, whānau and carers, aged-care providers, health care professionals, professional bodies, researchers, Māori and Pacific peoples and their service providers, government

Strategic context

The New Zealand Health Strategy provides the overarching framework and directions for our country's health system.



The New Zealand Health Strategy

The New Zealand Health Strategy describes the future we want, identifies the cultures and values that underpin this future and sets out five strategic themes for changes we can make that will take us toward its vision.

All New Zealanders **live well, stay well, get well**, in a system that is **people-powered**, provides services **closer to home**, is designed for **value and high performance**, and works as **one team** in a **smart system**.

New Zealand Health Strategy vision

The New Zealand Health Strategy provides the building blocks for this Healthy Ageing Strategy. Together they define how we will maintain and improve healthy ageing and independence, regardless of people's health status, and provide better support for older people with high and complex needs and at the end of their lives.

New Zealand Disability Strategy

The New Zealand Disability Strategy also informs the Healthy Ageing Strategy. It presents a long-term plan for:

A **society** that **highly values** the lives of people with disabilities and continually enhances their **full participation**.

New Zealand Disability Strategy vision

The Disability Strategy was informed by the United Nations Convention on the Rights of Persons with Disabilities, ratified in 2008. The Healthy Ageing Strategy is consistent with the articles of the Convention.

Positive Ageing Strategy

Government has a long-standing commitment to the vision and principles of the cross-government New Zealand Positive Ageing Strategy 2001, as reiterated in 2013 in *Older New Zealanders – Healthy, Independent, Connected and Respected*.

Older New Zealanders: **healthy, independent, connected and respected**.

Cross-government New Zealand Positive Ageing Strategy 2001

Government agencies are working with local government, towards a 'vision of a society where people can age positively and where older people are highly valued and recognised as an integral part of families and communities'.

Treaty of Waitangi and He Korowai Oranga

The health of older Māori is a priority for this strategy. We recognise and respect the special relationship between Māori and the Crown through the Treaty of Waitangi. In the health and disability sector, this involves working to the principles of:

- **partnership:** working with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services
- **participation:** involving Māori at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services
- **protection:** working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

Pae ora: Healthy Futures for Māori
wai ora, whānau ora, mauri ora.

Our approach to improving Māori health is guided by He Korowai Oranga, Māori Health Strategy. He Korowai Oranga has an overarching goal of pae ora, which translates to healthy futures for Māori. Pae ora comprises wai ora

(healthy environments), whānau ora (healthy families) and mauri ora (healthy individuals). Pae ora encourages everyone in the health and disability sector to work collaboratively, and to work across sectors to achieve a wider vision of good health for everybody. Implementation of He Korowai Oranga across the health system recognises and respects the principles of the Treaty.

‘Ala Mo’ui – Pathways to Pacific Health and Wellbeing 2014–2018

‘Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014–2018 is the Government’s national plan for improving health outcomes for Pacific peoples, families and communities. ‘Ala Mo’ui has four priority outcome areas:

- systems and services meet the needs of Pacific peoples
- more services are delivered locally in the community and in primary care
- Pacific peoples are better supported to be healthy
- Pacific peoples experience improved broader determinants of health.

Other national plans and initiatives

Other specific national strategies, action plans and work programmes influence the health of older people and guide programmes and services

on ways to meet their needs. These include:

- New Zealand Framework for Dementia Care
- Improving the Lives of People with Dementia
- Primary Health Care Strategy
- Living Well with Diabetes: A plan for people at high risk of or living with diabetes 2015–2020
- The New Zealand Carers' Strategy and Action Plan 2014–2018
- Pharmacy Action Plan 2016–2020
- Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017
- Review of Adult Palliative Care Services.

The Healthy Ageing Strategy incorporates several aspects of these population, service improvement and condition-related strategies and work programmes.

Global Strategy on Ageing and Health

Internationally, New Zealand is a signatory to the World Health Organization (WHO) Global Strategy on Ageing and Health 2016–2020, a five-year strategy for action to maximise functional ability for all, and build the evidence and partnerships for a Decade of Healthy Ageing from 2020 to 2030. The Global Strategy's five strategic objectives are:

- commitment to action on healthy ageing in every country
- developing age-friendly environments
- aligning health systems to the needs of older populations
- developing sustainable and equitable systems for providing long-term care (home, communities, institutions)
- improving measurement, monitoring and research on healthy ageing.

Taking a life-course approach

How well we age is influenced by our genetics, our upbringing, how healthily we live in our younger years and throughout our adult life and our exposure to health risks including poor housing, workplace discrimination and family violence.



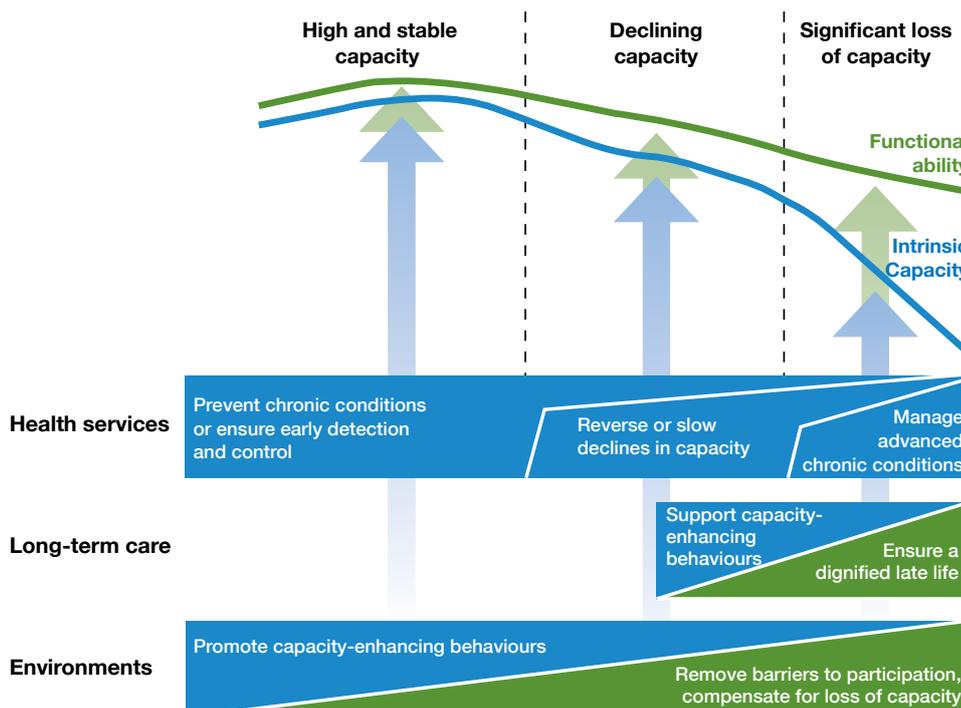
Also highly influential are our physical and mental capabilities; our access to resources and opportunities; our resilience including in the face of adversity; our relationships; our personal circumstances, including our occupation, level of wealth, educational attainment and gender; our potential for personal growth; and our cultures and sense of identity, security, value and wellbeing.

This strategy applies a life-course approach to achieving the aim of healthy ageing. It recognises that we age in different ways and have different needs at different times, and that our health is affected by our environment. The approach involves enhancing growth and development, preventing disease and ensuring every person functions to the highest capacity possible throughout their life. ‘Healthy

ageing’ does not refer to the absence of disease or physical or mental ill health. WHO defines healthy ageing as ‘the process of developing and maintaining the functional ability that enables wellbeing in older age.’

Initiatives for older people that take a life course approach, promoting ‘healthy ageing’, focus on building and maintaining people’s physical and mental function and capacity, maintaining independence and preventing and delaying disease and the onset of disability. Such initiatives aim to maintain quality of life for older people who live with some degree of illness or disability requiring short or long-term care. They enable disabled people to do the things that are important to them, enhancing their participation, social connection and appropriate care and ensuring their dignity in later years.

Figure 1: A life-course framework for healthy ageing



Source: WHO 2015

Challenges and opportunities

New Zealand's population is ageing. There will be a substantial increase in the number of older people over the next decade.



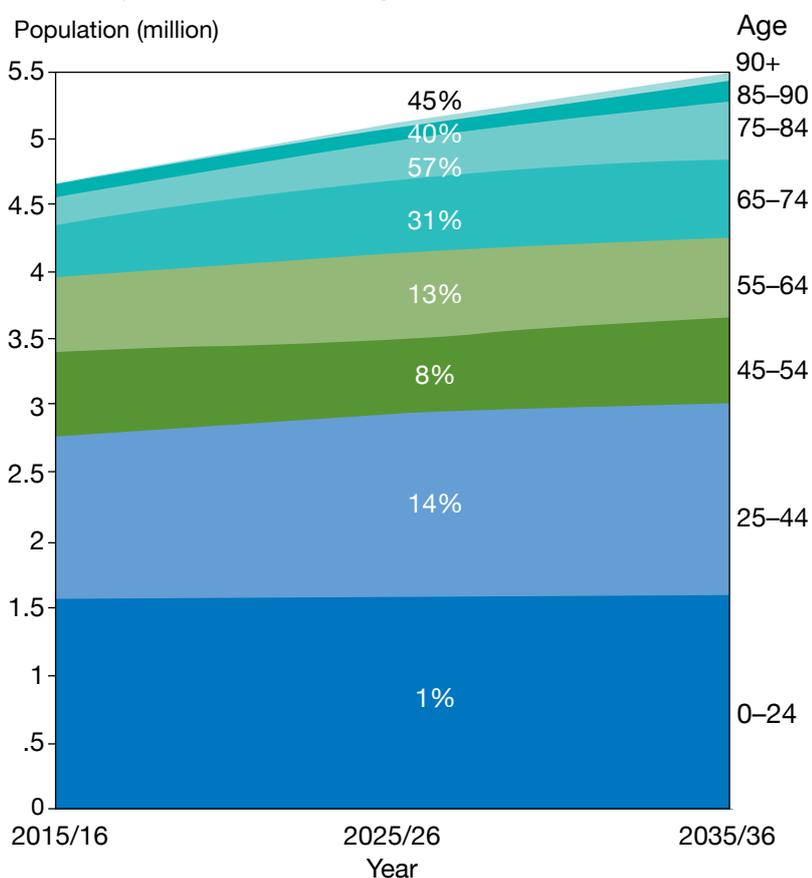
This older population, and our communities, will also become more ethnically diverse. The Māori population of people aged 65 and older is projected to increase by 79 percent in the 10 years to 2026. The older Pacific population is expected to increase by 63 percent, and the older Asian population by 125 percent in this same period.

The changing population has major policy, funding and planning implications. We need to plan well to make sure we are well equipped nationally, regionally, economically and socially. We need to have the right infrastructure in place to keep people in good health and provide for those who are not.

Currently, over one in six older people are living with three or more long-term conditions. Based on existing trends, an increasingly older population will mean steadily increasing health care needs. As a population group, older people have much higher rates of long-term chronic health conditions, and disabilities that require support on a daily or regular basis.

We are living longer, but the age to which we are likely to live in good health and without disability is not increasing at the same rate as life expectancy. At the age of 65, people can expect to live half of their remaining lives either free of disability or with functional limitations that can be managed without assistance.

Figure 2: Population projections by age group with 10 year percent change

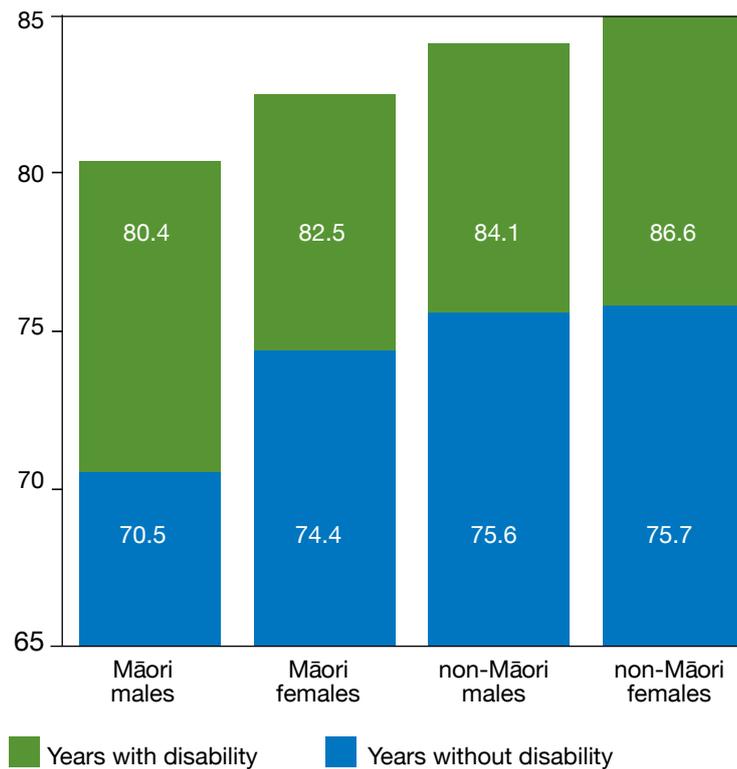


This is not the same for all population groups. In a comparison of Māori and non-Māori males and females, Māori males aged 65 can expect the shortest remaining time of living without disability or long-term illness (5.5 years on average) and the highest proportion of remaining time lived with disability requiring support (64 percent).

People with intellectual disabilities have some of the poorest health outcomes and can develop dementia at a younger age.

Source: Statistics New Zealand, 2016

Figure 3: Māori and non-Māori life expectancy at age 65



Source: Ministry of Health, 2013

Health inequities

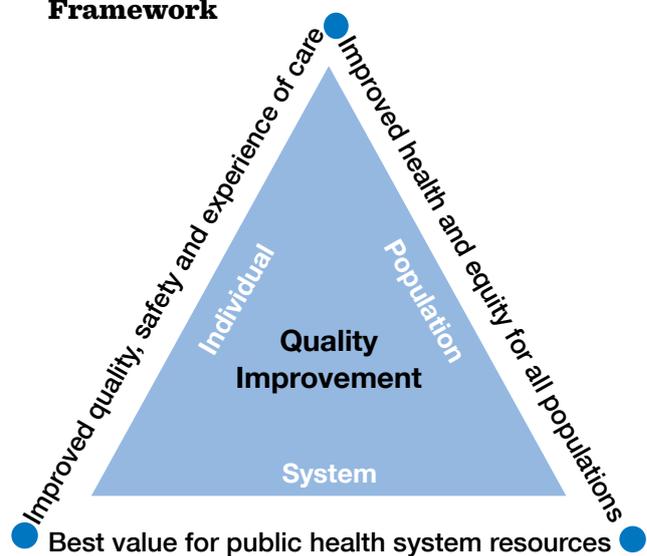
We need to continue our efforts to reduce inequities in health, so that all population groups can enjoy good health and participate fully in family and community life. In this respect, the Ministry of Health (the Ministry) focuses specifically on the health of Māori, Pacific peoples, migrant and refugee communities, people with disabilities, people with long-term mental health conditions or addictions and people with low incomes, who experience persistent inequities.

Achieving equity is a core component of the ‘value and high performance’ theme of the New Zealand Health Strategy. This is underpinned by the New Zealand Triple Aim Framework

for a whole-of-system approach to achieving, balancing and measuring improved health and equity for all populations, best value for public health system resources and improved quality, safety and experience of care.

To achieve equity, we need to understand and remove the barriers that prevent groups from experiencing equitable health outcomes, and build on the factors that enable equity. We need to work together with other sectors to address a range of barriers. The existing barriers we know about are infrastructural, financial and physical. Others can be difficult to articulate or identify.

Figure 4: New Zealand Triple Aim Framework



We need to better understand how well our services are working for different population groups, and why problems arise. This has implications for the way that the health sector conducts research, collects data and evaluates the effectiveness of services.

Staying healthy and independent in older age

We have an opportunity to reinforce and accelerate the positive trends we have seen in recent years. By focusing on preventing illness and by making it easier to choose healthy options (like eating healthy food, not drinking alcohol or only drinking at low-risk levels, and undertaking regular physical activity), we can help people to avoid developing long-term health conditions or slow the development of those conditions. Most importantly, we can do this by providing universal health services and public health initiatives that cover the whole population and by having services in place to intervene early and help people to return to good health and remain independent. As part of this, we need tailored approaches for some individuals and population groups, to help them access the same level of service and enjoy the same outcomes as others.

New investment approaches

If we continue to fund health services in the way we currently do, care of older people will account for 50 percent of DHB expenditure by 2025/26, up from 42 percent in 2015/16. It is vital that we ensure we are getting the best value from the investments and resources across the health and social sectors.

The Ministry and other government departments are taking new 'social investment' approaches to funding

services. These approaches provide significant opportunities for improving the health of New Zealanders in general and older New Zealanders in particular. One example of a social investment approach might be a concerted effort across government to reduce social isolation and loneliness, which we know have a strong relationship with poor mental and physical health outcomes and with increased problematic alcohol use.

Workforce development

The health system faces some significant workforce challenges. The health of older people workforce is itself ageing and some key workforce groups have experienced recruitment difficulties. For example, forecasts show that we will have trouble maintaining the necessary number of geriatricians and some other medical specialties, as well as registered and enrolled nurses, in aged care.

As people live longer with long-term conditions and complex needs, either at home or in aged residential care, we will increasingly need to support and develop the skills of our nursing, allied and kaiāwhina (unregulated care and support workforce) workforces. Some initiatives to sustain and grow the workforce are under way, including incentives to encourage graduate nurses to the sector and programmes to support teams working together across all settings. However, these are

not yet achieving significant gains. We need to be smarter in the way we make use of different parts of the workforce, such as the well-qualified pharmacist and allied health workforces.

We need to make a priority of attracting, retaining and making the best use of the skills in the health workforce to meet the needs of an older population. We need to ensure workforce training keeps pace with technological change, and retraining is easily accessible for staff, and is efficient and effective.

We also need to ensure that our health workforce appropriately reflects our growing ethnic diversity and ensure that it appropriately reflects and caters to a diverse older population.

Families and communities

We also need to ensure that family and whānau carers receive support and information to be able to appropriately and safely care for older people. These carers should also be supported to maintain their own health, and undertaking a caring role should not exacerbate any existing health conditions or disabilities.

We are starting to see the development of age-friendly communities in New Zealand. This term refers to communities that commit to physically accessible and inclusive social living environments that promote healthy and active ageing and a good quality of life, particularly for those in their later years.

Many are led by older people, together with local councils and a variety of organisations, who work towards local solutions to optimise older people's opportunities for healthy ageing, participation, security and quality of life. Age-friendly communities provide new opportunities for developing knowledge and skills for healthy ageing, and for the health sector to partner with older people in developing health and resilience.

Integration across the health and social sectors

Our approaches to the health and care of older people need to change at multiple levels. We need better communication between health service users and providers, to ensure that services are as effective and efficient as they can be. We need to improve the abilities of families, whānau, carers and communities to support and help care for older people. The health system needs to work with other sectors to take joint action on the social, environmental and economic determinants of people's health. Good housing and transport, for example, are critical to keeping people well in their own communities.

More collaborative approaches will enable us to be efficient and innovative in the way we utilise specialist roles, such as nurse practitioners, clinical nurse specialists and all health professionals including allied

health professionals, such as dental hygienists, dieticians, occupational therapists and radiographers; pharmacists and paramedics, to improve outcomes and enable innovative models to develop in home care, primary health care and residential care.

Smart system

Today's health system is data-rich, with a tremendous volume of information that can be harvested to create a much smarter system.

The value and high performance theme of the New Zealand Health Strategy emphasises the performance of the whole system and recommends the development of an outcomes-based approach to performance measurement. The Ministry has worked closely with the health sector to develop a suite of system-level measures that provide a system-wide

view of performance. Three of the measures in particular (acute hospital bed days per capita, patient experience of care and amenable mortality rates) highlight significant opportunities to improve the health outcomes of older people.

We're also able to make use of new technologies and information improvements. These technologies and improvements include initiatives that enable information to flow quickly and freely to older people and to health workers, providers and families and whānau; apps that provide immediate information on an older person's health status; and social media, which improves health professionals' options for connecting with older people, families, whānau and carers in diverse or isolated communities and helping them to connect more easily with the services and information they need. Improved information flows will also help agencies to collaborate more widely.



Vision and priorities for action

The vision for this Strategy is that: Older people live well, age well and have a respectful end of life in age-friendly communities.



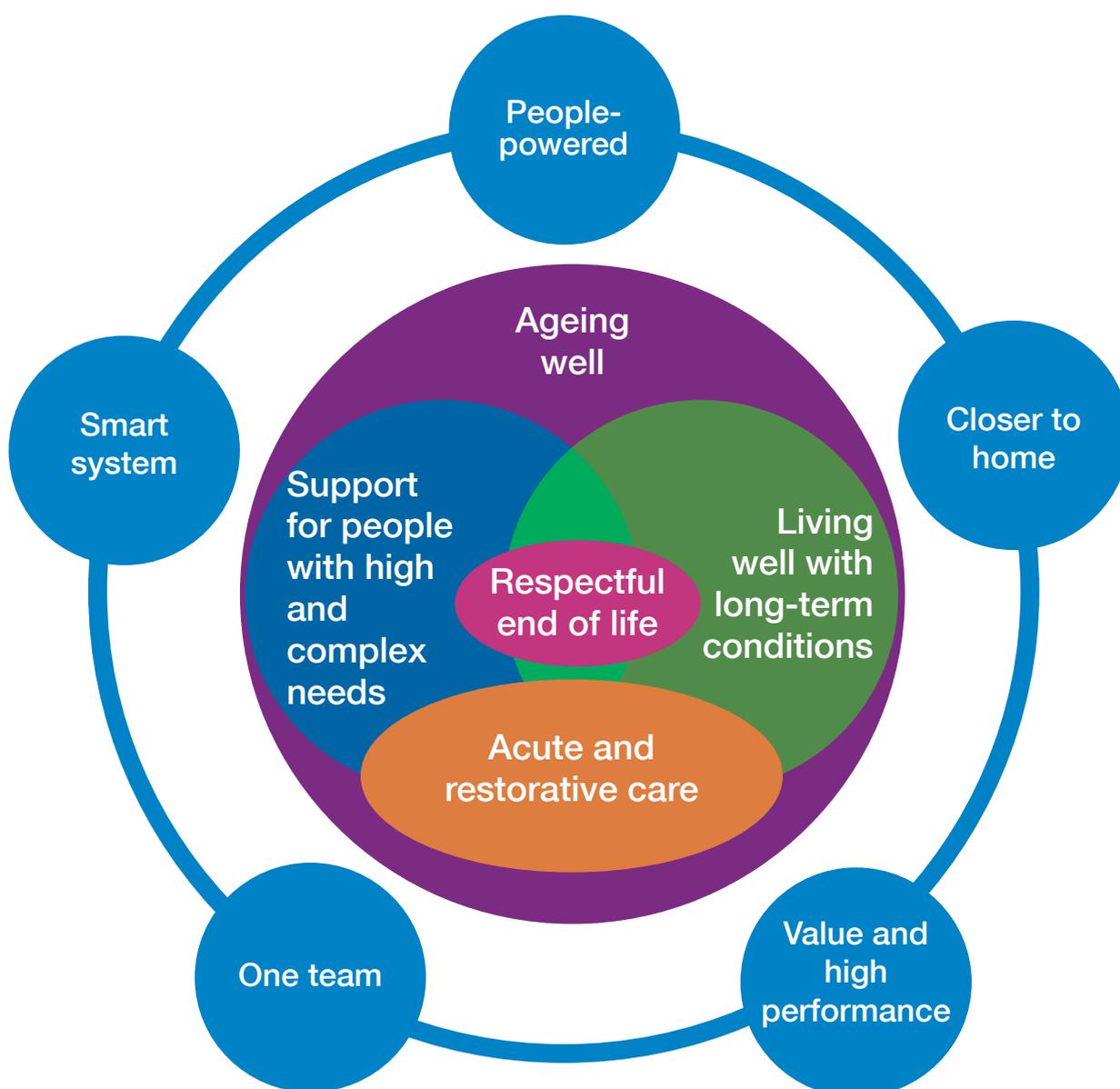
To achieve this vision, we need to ensure our policies, funding, planning and service delivery:

- prioritise **healthy ageing** and resilience throughout people's older years
- enable high-quality **acute and restorative care**, for effective rehabilitation, recovery and restoration after acute events
- ensure older people can **live well with long-term conditions**

- better **support older people with high and complex needs**
- provide **respectful end-of-life** care that caters to personal, cultural and spiritual needs.

These five outcome areas form the framework for this Strategy. We will set out to achieve our vision in these five areas within a system that, as the New Zealand Health Strategy requires, is people powered, delivers services closer to home, is designed for value and high performance and works as one team in a smart system.

Figure 5: Strategic framework for healthy ageing



Ageing well

Te pai o ngātau o te kaumātuatanga

This outcome area is about:

- maximising people's physical and mental health and wellbeing throughout their lives
- developing health-smart and resilient older people, families and communities to help older people age positively
- achieving equity for Māori and other population groups with poorer health outcomes
- taking actions to improve the physical, social and environmental factors of healthy ageing
- supporting the development and sustainability of age-friendly communities that enable older people to age positively.



Why this is important

Health is fundamental to being able to live well, age well and continue to participate in family and community life. Older people make a significant contribution to our society, economically, socially and intellectually as mentors, leaders and skilled workers and volunteers. A healthy ageing approach seeks to enable older people to continue to be active, engaged and enjoying life.

While people may experience some loss of strength and mobility over time, many of the conditions associated with ageing (such as frailty) are not inevitable. The WHO estimates that more than half of the health conditions older people experience are potentially avoidable through lifestyle changes. There is increasingly clear evidence that healthy lifestyles and physical and mental resilience are determinants of health in older age. There are also many opportunities to benefit longer term from investing in social and environmental factors that influence health.

Ageing well is not just about preventing ill health and disability. It is also about maximising physical and mental health and wellbeing, independence and social connectedness as people age. Healthy ageing relates to all older people, including people with life-long disabilities or long-term conditions, those recovering from injuries or poor health, those with high and complex needs and those in their final stages of life. Subsequent chapters build on this chapter.

Investing in healthy ageing has the potential to increase the proportion of healthy, active and independent older people, prevent long-term conditions and their impacts on people's lives and result in long-term savings to the health system.

A healthily ageing and robust population would help enable individuals to continue participating in their communities and contributing economically, socially and intellectually to a greater extent. Fewer people would require acute health interventions and would be able to stably maintain themselves if they developed chronic health conditions.

To ensure people age well, we need to focus on:

- building physical and mental resilience
- achieving equity in health across all population groups
- developing a health smart population through health literacy and helping people to plan for their future health and health-related needs
- a health system that supports healthy ageing closer to home
- supporting people to plan for future health and health-related needs
- improving social, physical and environmental determinants of health
- promoting and supporting the development of age-friendly communities.

Resilience

Resilient people are more likely to age well and avoid cognitive decline or loss of function until very late in life. Resilient people can overcome stressful obstacles and recover from events that might tip a less resilient person into a state of poor health.

Resilience develops through physical activity, healthy behaviours, mental wellbeing and social connectedness. Our focus is therefore on increasing physical activity and other healthy behaviours among older people – for example, encourage good nutrition, not drinking alcohol or only drinking at low-risk levels, not smoking tobacco, taking part in mentally stimulating activities and relationships that build people's strengths and resilience.

People staying active and connected as they grow older is critical. There is strong evidence that social isolation or loneliness is linked to poor mental and physical health outcomes. We need to increase awareness of this fact across the health system, and join with social sector agencies, as well as community and voluntary organisations to reduce this risk factor and increase social interaction and connectedness.

We must also improve mental wellbeing among older people. Social connectedness, nutrition, physical health and activity all contribute to mental health, as does an environment

that promotes older people's sense of self-worth and value to others. We need to continue to reduce the stigma of depression and anxiety among older populations, and promote the factors and supports for greater mental wellbeing. We need to foster approaches that build people's strengths and capabilities, increase optimism and hope and reduce the potential and impact of depression, anxiety and cognitive decline.

Equity

Reducing health inequities is a core component of a healthy ageing approach and a priority for government. Equity is defined by the WHO as 'the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically.' Health equity approaches aim to improve fairness and reduce the incidence of avoidable, undesirable differences in health status.

People differ in their ability to attain or maintain good health, for many reasons. Some population groups have markedly poorer health outcomes: Māori, Pacific peoples, people with intellectual disabilities, and people in socioeconomically deprived areas. Other groups, such as ethnic communities and rural communities, are also vulnerable to poorer health outcomes.

Our focus on health equity aims to increase the age which these groups can expect to remain in good health and independence and includes:

- ensuring equity of access to health services, including through innovative and effective services provided closer to home, and catering to people’s cultural preferences
- enabling equal opportunities to raise the capacity, functional ability and wellbeing, by directing resources at those with greatest need
- removing physical, financial, institutional and other barriers to high-quality health services and equitable health outcomes
- working across government and in communities on the social determinants of health, including housing, elder abuse and neglect, negative attitudes and discrimination, social isolation and inclusive, age-friendly communities
- minimising the impact of disability and illness on people’s lives.

Being health smart

Health literacy

People are empowered in their everyday lives when they can make decisions that positively affect their health and care. Health literacy is the capacity to make good decisions, act on health information and navigate the health system. It is an essential component of resilience and a priority of this Strategy.

Empowering and supporting older people to be ‘health smart’ in their later years requires the health system to have a strong understanding of what it takes to age well and take part in achieving healthy ageing. We will support older people in a way that is meaningful for them, and that is fully inclusive, where people are at the centre of the process. We will make health information available and shared in a way that overcomes cultural and communication barriers.

Planning for the future

People’s needs change as they age, and there may become a time when a person is no longer able to make decisions or advocate for themselves. Advance care plans and enduring powers of attorney allow an individual to retain a degree of autonomy in relation to their health care and treatment, minimise the potential for conflict or harm, and reduce stress on family members and others. There is some evidence that advance care plans can improve the experience of end-of-life care and their use across clinical disciplines is an integral part of a dying person’s coordination of care.

Advance care plans and the discussions around them create an opportunity for people to think and talk about their values, preferences and beliefs. These conversations are easier when they begin well before the end of life. However, as people’s preferences often change over time, it

is also important that they be reviewed and updated at key points and when circumstances change.

The New Zealand Health Strategy commits to supporting people and their clinicians to develop advance care plans by building on existing national and international resources and networks. We can also promote advance care planning through, for example, community organisations, to help reduce stigma around talking about death and dying, and to increase the likelihood that people receive quality health care according to their wishes. The quality of care is further discussed in the 'Respectful end of life' section.

We know that financial security is also important for mental wellbeing and healthy ageing. The Commission for Financial Capability is carrying out a national strategy and leading work across government and together with communities to grow New Zealanders' financial capability. Better financial capability will improve family and community wellbeing, reduce hardship, increase investment and grow the economy, contributing to everyone's resilience.

High-quality care closer to home

Primary health care services are generally people's first interaction with the health system when they are unwell. They are where people receive most of their professional medical advice.

A strong, well organised primary health care system that is provided close to where people live and work will empower individuals, enabling them to make informed choices and supporting them as they navigate their way through the health system. They also reduce health inequities and improve population resilience.

Improving the social and environmental factors influencing health

Together with other government sectors and communities, the health system will work to improve the social, economic and physical factors for healthy ageing and achieve equity, removing barriers to participation.

We need a coordinated, system-wide approach to preventing, identifying and reducing elder abuse and neglect that includes providing accessible, well-tailored, effective services. As part of the Ministerial Group on Family Violence and Sexual Violence work programme, the health, social and justice sectors are working together to develop an integrated system for preventing and responding to family violence and sexual violence, including elder abuse and neglect, and reducing the impacts of such violence on wellbeing. The work is built around people-centred service design and delivery, in the four areas of primary prevention, identification, incident response and follow-up responses.

We will work with housing providers to improve the quality and range of age-friendly housing for older people. This will include a focus on rental housing stock, which older people are increasingly likely to live in, and supported living housing options. We will work with social housing providers to ensure that social housing is warm, safe and dry, and with others to promote options for housing that meet the needs of an ageing population. We will also look for opportunities with the housing development sectors to understand the future housing needs of an ageing population.

Transport solutions are needed to reduce social isolation and improve older people's ability to participate in their communities and access health and other social services. Government agencies will work with transport providers to increase access to alternative means of transport for older people, to help prevent isolation. They will work to increase the flexibility of social services in areas where transport options are most limited.

Whānau ora service approaches are examples of how agencies can work well together to reduce the social, physical and environmental barriers some people face to achieving good health and wellbeing.

Age-friendly communities and workforce

Age-friendly communities are accessible and inclusive. They value people of all ages, and optimise opportunities for healthy ageing, including in the areas of participation, dignity, security, and quality of life. Age-friendly communities ensure older people have a voice, including those with disabilities and dementia, and marginalised older people. They recognise older people's wide range of skills and resources, and ensure that communities protect those who are most vulnerable. They anticipate and respond flexibly to the changing physical, mental and social needs and preferences of older people and ageing populations.

The 'age-friendly' concept and its implementation have significant momentum internationally and are starting to gain pace in New Zealand. The Office for Seniors will lead the development, through a co-design process, of a New Zealand-centric approach, and further develop the resources and networks to guide communities through the process of becoming age-friendly.

Across central and local government agencies, and in partnership with communities, we will support older people and promote age-friendly communities throughout New Zealand. We will support older people and others leading age-friendly communities

locally. Together we will work to improve policies, services, structures and environments, particularly outdoor spaces and buildings, transport, housing, social participation, respect and social inclusion, civic participation and employment, communication, and health and social services. Our collaboration will enable collective impact at the national, regional and local levels.

An integrated health workforce with knowledge of social determinants of health, culturally competent and with a focus on wellness and upstream early intervention in supporting healthy lifestyles is an important contributor to age-friendly communities.

Goals for healthy ageing

- Older people are physically, mentally and socially active, have healthy lifestyles and greater resilience throughout their lives, meaning that they spend more of their lives in good health and living independently.
- Older people are health smart, able to make informed decisions about their health and know when and how to get help early.
- Everyone in the health system and in the wider social sector understands what contributes to healthy ageing, and takes part in achieving it.
- All older populations in New Zealand are supported to age well in ways appropriate to their needs and cultures.
- Communities are age-friendly with initiatives to keep people healthy, well-connected, independent, respected and able to participate fully in their communities and with family and whānau.

Acute and restorative care

Ngā tuāhuatanga manaaki, whakaora i te hunga māuiui

This outcome area is about:

- ensuring appropriate admissions to hospital for older people with acute or urgent clinical/care needs
- coordinating care across specialities and between ACC and the health sector
- ensuring hospital stays are safe for older people who are frail, vulnerable or have dementia
- helping older people to regain, maintain or adapt to changed levels of function after an acute event
- looking for ways to weave family or whānau and wider community support into an older person's recovery and ongoing functioning.



Why this is important

Older people benefit from access to a wide range of hospital services, including emergency or acute services. But unnecessary emergency visits, and inappropriate admissions are stressful for the individuals and use valuable resources.

Ambulance services and emergency departments are generally the first services to deal with acute and potentially life-threatening situations. But they may not be the best places for older people whose conditions could be managed at home or by their local primary health care clinics or aged residential care homes.

Once in hospital, older people can be especially vulnerable to rapid deterioration putting them at risk of further harm (eg, by acquiring an infection).

When older people stay in hospital too long, they face the risk of further decline in their health associated with reduced physical activity (leading to loss of muscle tone and the chance of bed injuries), stress leading to increased confusion, and inappropriate medication.

These factors can lead to loss of confidence and social contact and are strong predictors of increased length of stay, long-term cognitive impairment, complications or death, as well as higher costs for care. They can also mean a slower recovery for the individual and increased distress for family, whānau and carers.

However, at the other end, premature discharge may result in loss of functioning or condition in the older person or even readmission. Premature discharge can also cause significant stress for family, whānau and carers who feel unprepared and unsupported.

When an older person returns home after a stay in hospital, they may need to make adjustments to their daily routines, and they may require temporary or ongoing support. Re-integration to family, whānau and community life is a key goal at this stage.

Successful treatment of an acute event and effective follow-up care are reliant on proactive and integrated planning, timely treatment and a team approach. Planning needs to involve the individual and their family and whānau and should address physical, mental and spiritual aspects.

Service providers and staff need to understand cultural and other preferences, and be committed to working with Māori, Pacific and other organisations, families, whānau and community leaders to get the best outcomes possible for individuals.

Older people told us that they want their:

- urgent care needs managed at the right level (that is, don't take them to hospital if they don't need to go there)
- assessment and other important information to be available to all who need it (that is, not to have to repeat their information several times over)

- families, whānau and carers involved in their rehabilitation and planning for their return home
- discharge, ongoing rehabilitation, home support and equipment organised in a timely way.

Therefore we will focus on improving the three main parts of the journey for older people – managing acute presentations, providing safe, quality treatments in hospital stay, and ensuring supported discharges and rehabilitation into the community.

Managing acute presentations

To reduce unnecessary admissions, we need a system-wide response, including prevention, timely primary health care responses for older people with acute needs, better communication between providers and systems, coordinated clinical and social care, links between regular hours and after-hours services, and engagement with community providers.

The first stage of the journey is prevention. A range of people can have a role in this stage, including general practitioners, pharmacists, physiotherapists and home support workers. All these primary care givers should be able to recognise a deteriorating or acute situation and know where to go for further advice before calling on emergency care services.

Family and carers could be the ‘eyes and ears’ of an older person’s care team and initiate timely interventions.

Some DHBs have developed ‘pathways of care’, that is, guidelines for assessing and managing particular conditions (eg, strokes or heart disease) to improve the coordination and documentation of care. Such pathways can reduce unplanned referrals to hospital.

We need to spread innovations that reduce the need for unnecessary intensive services.

Ambulance services in the Kāpiti Coast region, out of Wellington, are using an ‘urgent community care model’ and Healthline, as well as frontline triaging in emergency departments. Gerontology nurse specialists in the Waitemata DHB provide assessments and care coordination across primary health care and hospital services for complex wound care to be managed in the home or aged residential care setting, thus reducing the risk of an older person’s health deteriorating and the need for acute care.

We will encourage and support such innovations, evaluate their outcomes and spread good practice.

Safe, quality treatment in hospital

Hospitals can be frightening and bewildering places. Hospital staff need to be acutely aware of the vulnerability of older people, especially those who

are frail, experience dementia, have complex conditions or disabilities or could become delirious.

Many older people have multiple conditions, which can lead to transfers between specialists or hospital departments and lack of overall coordination. We need geriatric specialists to assist with assessments and care planning. Equally important, a range of health professionals need to be trained to deal with the common conditions and complications associated with caring for older people.

A comprehensive collection of clinical and personal information will already exist for some older people, for example through an interRAI assessment or gathered by their primary or community health care team. There is scope for these providers to share information to improve care planning and reduce duplication. Such information needs to be accurate, accessible, easy to interpret and up to date.

Joint initiatives between ACC, the Ministry and the Health Quality and Safety Commission New Zealand are underway to reduce patient harm and improve analysis and data sharing on patient safety and treatment injury.

This work aims to enable continuous quality improvements and help reduce disparities in care between injury and non-injury patients.

Space and time are often short in hospital, especially in emergency settings. Nevertheless, respecting

cultural preferences and practices, for example, by creating enough space to accommodate extended family and whānau, can help improve the patient and family experience of care.

Around one-third of deaths among older people occur in hospital, including in acute settings. Links with palliative care services are therefore critical. Advance care plans (ie, documentation around the goals and limits or ‘ceilings of care’) and enduring powers of attorney need to be readily accessible.

Supported discharges, rehabilitation and restorative care

‘Rehabilitation’ refers to the process by which health providers assist a person to recover from a procedure or event and regain, maintain or attain as much functioning as possible. The term ‘restorative care’ is also commonly used to refer to the building up of a person’s capacity and resilience to maximise their autonomy.

Preparation for being discharged home needs to begin as early as possible, and it is critical to engage the family or whānau and carers who will be involved in providing on-going support in the home and community as well as the various members of the clinical care team. This is commonly referred to as ‘early supported discharge’.

Internationally, there is not a large body of consistent evidence on the best way to transition people from hospital to

home. But there are promising models already in use and plenty of scope for further trials and evaluation. We need to support innovation, collect data and share results to build the body of evidence and develop best-practice approaches.

Some DHBs have dedicated teams to plan and manage 'early supported discharge', for example START and CREST Team in Waikato and Canterbury DHBs respectively.¹ Such teams have been shown to be effective in reducing a person's time in hospital, preventing readmissions and lower costs overall.

In other areas, district nursing services provide clinical care and oversight of rehabilitation – sometimes home based, sometimes in a community clinic.

Some people need longer periods of time to recover and a different setting and benefit from a 'step-down' or 'intermediate care' provided after discharge from hospital, but before it is possible for them to return home.

For example, in some parts of the country, aged-residential care facilities provide a safe place for ongoing rehabilitation, which also includes training for family, whānau and carers.

Wherever rehabilitation occurs we are looking for a shift in philosophy from simply doing things for people, to

working with people to help them regain or maintain their ability to manage their day-to-day needs.

For some people, this will mean finding a new balance – adapting to changed or reduced levels of functioning, including addressing the psychological and social effects of this change, for example after a stroke.

Clarifying an individual's goals and motivations is a key part of developing a personalised care plan, and provides a way to recognise and respect cultural preferences.

Family and whānau involvement is critical to supporting the older person through their rehabilitation, and it is important to identify any help the carer needs to be able to provide that care in a safe and sustainable way.

Volunteer groups can also play a valuable role, (eg, stroke support or cardiac companion groups).

Integration in the health sector and across agencies

Funding for rehabilitation and recovery services is currently spread across different parts of the health system, including health, disability and ACC (and occasionally New Zealand Veterans' Affairs). This can lead to duplication of services, or gaps and delays in coordinating care (eg, a person needing home care, district nursing, nutrition advice and equipment may face four different assessments).

¹ Supported Transfer and Accelerated Rehabilitation Team and the Community Rehabilitation Enablement and Support.

Streamlining assessments, standardising the use of shared care plans and routinely using multi-disciplinary teams might make any funding differences invisible to the person needing services.

Workforce

A variety of different workforces with complementary skills support the health and wellbeing of older people. In all settings, staff need an understanding of common conditions for older people such as frailty, confusion, falls, or risk factors such as incontinence, pressure injuries or polypharmacy.

Ideally, there should be multi-disciplinary teams involved in care planning and delivery. This ensures comprehensive coverage, and coordinated care. Integrated technology and tools (such as shared electronic records) can provide greater flexibility by supporting 'virtual' teams'

We need a skilled generalist workforce and a specialist workforce that provides both clinical services to individuals, and training and support to allow other staff to work to the top of their scope.

Allied health staff (such as occupational and speech language therapists, dieticians and physiotherapists) have key skills for rehabilitation, recovery and restoration, but access to them can be limited. Greater integration will rely on more flexible access to such staff.

Kaiāwhina and family or whānau need to be involved in rehabilitation. Information sharing, training and other means of support could enhance the range of support activities they undertake, and improve their confidence and ability to provide ongoing care throughout the rehabilitation period.

The health and disability workforce needs to be able to respond to our ethnically diverse population and to deliver services and supports in culturally competent ways.

Quality

Quality measures in this area need to include individual experiences and outcomes; for example, can the person now dress themselves? Was the person satisfied with their recovery? Did their family or whānau feel supported to help with their rehabilitation?

Quality measures can also include 'system' measures, such as the number of acute bed-days, and contributory measures, such as whether discharge was timely and support services were in place, and whether the person was readmitted to hospital within a short time.

Quality is an ongoing process that needs to be supported by the provision of up-to-date evidence to inform and spread best practice.

Technology

Arrangements are in place in most areas of the country to ensure that primary health care practices are advised whenever a person uses an ambulance or emergency department service. This needs to be available across the country, and potentially extended to other areas such as aged residential care.

An increasing array of electronic reminders and measurement and monitoring tools are available to assist rehabilitation. We want to see both health professionals and older people supported to use such tools effectively.

Shared patient records that include assessment information and care plans and that indicate how people want to be treated at their end of life, are critical to support care coordination.

Goals for acute and restorative care

- Innovations and research support best practice triage, assessment, integrated care, discharge planning, rehabilitation strategies, and follow-up support.
- Older people are supported through recovery by specialists and general staff who are competent to deal with common conditions, including frailty, delirium or dementia. Hospital staff and processes respect cultural preferences and differences.
- Family, whānau and carers are included in discharge planning and receive training and support to provide ongoing rehabilitation in home and community settings.
- Quality measures include patient experiences as well as clinical outcomes.



Living well with long-term conditions

E noho ora ana i roto i ngā mauiuitanga o te tinana

This outcome area is about:

- giving individuals the tools and support they need, including guidance, information and access to technology, to manage their long-term conditions to a comfortable level and reduce the impact of those conditions on their lives
- ensuring all health professionals and social services have the tools and support they need, including information and resources, training, models of care and access to technology, to detect long-term conditions at the early stages and treat, rehabilitate and manage them well
- improving social assistance, primary health care and home and community services and supporting family and whānau carers to help older people with long-term conditions live well
- improving our ability to slow or stop the progress of long-term conditions towards frailty.



Why this is important

The WHO has referred to long-term health conditions as ‘the health care challenge of this century’. Long-term conditions include diabetes, obesity, cardiovascular and chronic obstructive pulmonary disease (COPD), cancer, asthma and other respiratory conditions, arthritis and musculoskeletal diseases, stroke, chronic pain, dementia, mental illness and addiction. Long-term conditions also include physical, sensory and intellectual disabilities.

With an ageing population, the numbers of people living with long-term conditions are expected to increase. Long-term conditions can occur at any age, but become more prevalent and are more common among older people. Currently one in six older New Zealanders are living with three or more long-term conditions. For example, the numbers of New Zealanders with dementia is expected to rise to 78,000 by 2026, from an estimated 50,000 currently. Some population groups, such as people with intellectual disabilities, and Māori and Pacific peoples tend to have higher rates of long-term and age-related conditions at earlier ages.

Long-term conditions are often complex, with multiple causes. They can lead to a gradual deterioration of health and mobility but can also become acute suddenly, resulting in hospitalisation and sometimes

dependence on long-term support services or family and whānau.

Higher rates and greater complexity of long-term conditions will increase demand for health services in general, and home and community support services in particular. This will also mean that increasing numbers of people will be caring for and supporting family and whānau members.

The New Zealand Health Strategy’s overarching goal is to see all New Zealanders live well, stay well and get well, and therefore spend more of their lives in good health. As part of a healthy ageing approach, for those with long-term conditions, our focus is on reversing or slowing declines in health and function, and promoting and supporting the behaviours and other factors that enhance people’s capacity. We want to ensure that older people with long-term conditions retain the highest level of mental and physical function possible; they enjoy life, and their communities respect them.

To achieve these goals, we will take steps to improve the detection of long-term conditions, including where mental health and addiction issues are involved, which may mask as well as contribute to symptoms of other long-term conditions. We will help New Zealanders become more health smart, so that they are better able to manage their conditions and get the help they need to stay well. We will improve the health workforce’s ability to work

with older people who have long-term conditions so that those people are able to live well with their condition, and we will strengthen home and community support services so that they are better equipped to support people with long-term conditions and their family and whānau.

Prevention and detection

A major theme of the New Zealand Health Strategy is to have New Zealanders become more health smart. To create a health smart population, we need to provide individuals, as well as family and whānau and carers, with information about preventing long-term conditions.

For those living with long-term conditions, we need to provide information about specific conditions, symptoms, medication and management, as well as the importance of healthy lifestyles. We also need to enable people to connect with groups and organisations that can help them to manage their conditions.

We need to improve our ability to prevent and manage long-term conditions that lead to the development of frailty.

There are a number of ways in which we can minimise the harm of sensory loss and the loss of functional ability in older people. Timely recognition of emerging sight and hearing issues, for example, using appropriate assessments for

functional impact, and improving our approaches to enablement can make a significant difference to how well people are able to live and participate in everyday life and remain independent.

Priority populations

Long-term conditions contribute to the higher rates of illness, disability and death experienced by Māori, Pacific peoples, people on low incomes and people with disabilities. We will prioritise reducing health inequalities and other adverse outcomes for people with long-term term conditions.

We need to ensure that older people of all ethnicities are health literate and can access culturally appropriate services including home and respite care, long term residential care, mental health and dementia services. The health workforce should also reflect our growing ethnic diversity. We will do this in partnership with these population groups and their families and whānau, and the providers and NGOs that represent these population groups.

Dementia is a particularly prevalent long-term condition in older ages, and an important priority. We will implement the New Zealand Framework for Dementia Care (see Ministry of Health 2013) to give people who are living with dementia the best possible independence and wellbeing.

Living well with long-term conditions requires identification, interventions,

information and advice relevant to specific conditions. We will investigate and, where appropriate, deliver relevant approaches for people living with stroke, musculoskeletal conditions, dental conditions, low vision and diabetes.

Enabling technology

Technological tools such as smartphones, apps and wearable devices have many valuable applications in the area of health. They will become increasingly important as a way of allowing older people to maintain autonomy, dignity and a better quality of life, including through the ability to remain living in their own homes for as long as they wish. The pace at which older people adopt such tools will vary. We need to ensure that late adopters continue to have equal access to the services they require.

Health workforce and service delivery

As the proportion of older people in our society grows, the health workforce will need to become more adept at caring for them, and more knowledgeable about what keeps older people healthy and resilient. We will expand the capability of the workforce through professional development and smarter models of working.

Primary health care, pharmacists and home and community support services are well placed to take a greater role in the care and support of people who

need assistance to remain living at home, for example, through medicine optimisation services.

We need to accelerate improvements in the models of primary health care to ensure that it is able to respond to the challenges of a diverse older population with higher rates of co-morbidities.

In the case of home care, we could better align service models, funding methods and levels of training, to allow a greater level of involvement with other parts of the health system. At present, the home and community workforce is fragile. Jobs in this sector are generally characterised by low pay, irregular working hours and variable access to training, which contributes to high staff turnover.

We will invest in the home and community support workforce and develop service and funding models. Models will take a sustainable, culturally appropriate, equitable and person-centred approach to supporting older people with long-term conditions. This will include consideration of the role of individualised funding and retirement villages.

Family and whānau

Family and whānau carers play a vital role in providing support for older people with long-term conditions. We will ensure that such carers receive the support they need. This will include training and information, as well as

different, flexible forms of respite care so that they can look after their own wellbeing, in particular their mental health. Family and whānau carers should not be in a position where they become isolated because of their caring role.

Goals for living well with long-term conditions

- Improved methods of early detection and prevention result in fewer older people being affected by long-term conditions or frailty.
- Older people with long-term conditions retain the highest level of mental and physical function possible; they enjoy life and their communities respect them.
- Older people with long-term conditions are 'health smart',

are actively self-managing their conditions to a practical and comfortable level and are supported to do so closer to home.

- The workforces that support older people with long-term conditions, including the health workforce, home and community support services and family and whānau carers, collaborate and have appropriate resources, structures and training and work in an integrated manner.
- Home and community support services are equitable and appropriate to older people's needs and preferences and maximise their wellbeing.
- Health outcomes for vulnerable older populations with long-term conditions are equitable, with good outcomes for the population as a whole.

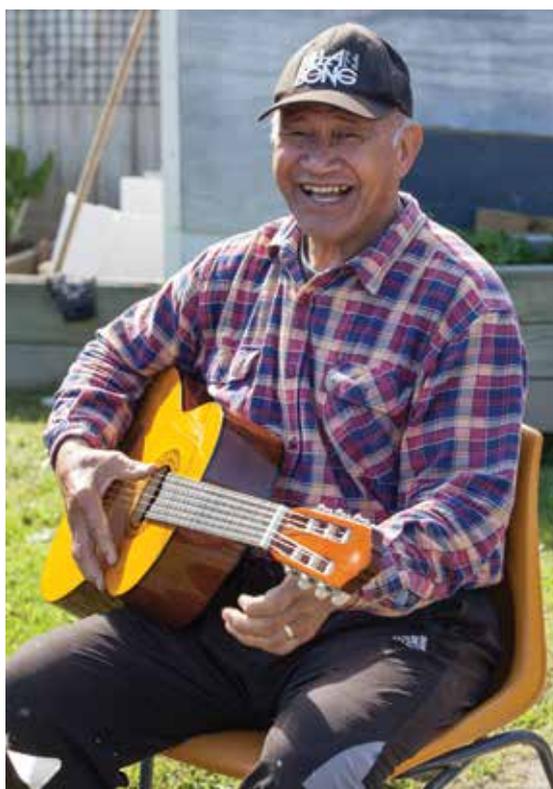


Support for people with high and complex needs

He tautoko i te hunga pakeke he uaua, he maha hoki o rātau taumahatanga

This outcome area is about:

- building on the vision and actions of previous outcome areas to consider issues particularly relevant for older people with high and complex needs
- ensuring people are in the right place to receive the care and support that most appropriately meets their needs
- individuals maintaining choice and control when they need significant support
- helping families and whānau to provide the best support they can while maintaining their own wellbeing
- coordinating, integrating and simplifying health and social services for older people with high and complex needs
- providing flexible home and aged residential care services that suit the needs of the increasingly diverse older population
- reducing avoidable visits to emergency departments and acute care among a group of potentially high users
- enabling all older people with high and complex needs to easily access care and support, irrespective of their financial position
- promoting innovative models of complex care that better support older people, their family and whānau and carers
- ensuring value and high performance for services that use a large proportion of the health budget.



Why this is important

Older people with high and complex needs are one of the most vulnerable groups in society. They are more likely to become 'frail'; that is, to deteriorate markedly after an event that would commonly have a minor effect on other older people's health. The number and complexity of conditions in older people with high and complex needs makes treatment and care more difficult, as conditions and treatments affect each other.

For some people with high and complex needs, moving into aged residential care improves the quality of their lives in their remaining years.

This part of the Strategy expands on the goals and actions relating to long-term conditions. Doing more to support older people with high and complex needs is particularly relevant for the population of Māori and Pacific older people with high and complex needs, given the higher rates of Māori and Pacific people in this category. There are good examples of health practitioners, purchasers and providers partnering with Māori and Pacific providers to develop services that meet the needs and aspirations of Māori and Pacific people in culturally appropriate ways for individuals and their families and whānau.

Knowledge and communication

Older people with high and complex needs require more information than

usual to make choices about the care or support they want to receive; clarity of communication is vital.

Some older people with high and complex needs have lost or are losing their mental capacity to make full and rational choices, so health care providers need to communicate their care options with a wider group, including family and whānau and carers.

Older people with high and complex conditions have to navigate their way through more parts of the health and support system than other older people. These services need to communicate and work well together to ensure such people are well supported with their health care.

Technology

Technological tools such as smartphones, apps and wearable devices are making it increasingly easier to monitor a person's health and communicate health information. Health service providers will pay particular attention to each individual's ability to use such devices and accommodate a range of technical literacy levels.

Services closer to home

Older people value their independence highly. They do not want to be seen as a burden on spouses, family or social services. They want to stay in their communities, and access services closer to home. High performing primary care and home care service

models referred to in the long-term conditions chapter are particularly important for people with high and complex needs. We will also strengthen health and social sector coordination, workforce and support family and community in their roles as carers.

Health and social sector coordination

Older people who are developing higher and more complex needs generally receive better care when their primary health care service is close to their home. It is easier for the health professional caring for them to have more regular contact with them and know more about their situation and their lives.

Older people who need to see a variety of health professionals want their individual health information to be available to all the clinicians they see so they don't have to retell their story repeatedly. We will develop systems so that clinicians are informed about patients' other conditions and treatments.

Health services for older people with high and complex needs can be very expensive. We will therefore be careful with our use of resources so we can help more people. We will design care for older people with high and complex needs with value and high performance in mind. Our approach will take into account the full range of influences on older people's outcomes, including the resources across the health and social

systems, people's experience, service quality and the impact of services on whānau.

To achieve best value and high performance, DHBs will commission services that provide older people with quality care in the right setting at a sustainable cost. This can involve identifying potential health issues and instituting preventive care plans in response.

New Zealand's health system needs to better support the older population groups that do not enjoy the same health as New Zealanders as a whole. These groups include Māori and Pacific peoples, disabled people and those with long-term mental health issues and alcohol and other drug addictions.

Our focus will be on removing barriers to delivering high-quality health services, within the health sector and between it and other sectors. Improving the health of vulnerable groups may involve better tailoring services for accessibility, making services available at more suitable times, or delivering services in more culturally appropriate ways.

Workforce

People working in teams that contain a range of health specialties need to see themselves as part of one team supporting integrated care that is provided closer to home. We will reduce the barriers that currently prevent people from using their skills flexibly and fully.

The workforce needs to ensure that the services are culturally appropriate to meet the needs of a wide range of ethnic communities.

Support workers make up a large part of the workforce for people with high and complex needs. We will pay, train and value these workers as part of the integrated 'one team'.

Family and community

Beyond the formal workforce, we will support families and whānau and others in their roles as carers of older people with high and complex needs. This support could involve health literacy education, and training specific to the carer role, and having regard for the carers' own health needs, particularly in relation to mental health.

Older people with high and complex needs often have comprehensive clinical assessments of their needs electronically recorded in the interRAI database. Care providers use this information to develop care plans. The information will be a rich resource for the range of health professionals dealing with each person and for PHOs and DHBs learning about the outcomes of older people receiving support services in a location or population group.

Goals for supporting people with high and complex needs

Older people with high and complex needs:

- are able to live as independently and actively as possible
- have the information and freedom to make good choices about the care and support they receive
- know that health care workers understand their wishes and support their needs
- are assured that information about their circumstances and needs flows easily between health care workers who work in an integrated manner
- have care plans that reduce the likelihood they will deteriorate markedly after a health event
- are able to access care and support irrespective of their financial position
- experience equitable access to services and equitable outcomes regardless of ethnicity or rural location
- move easily to and through care settings that best meet their needs
- have reduced need for acute care.

Families and whānau and carers have the support, information and training they need to assist older family members, and the stress of caring does not affect their own health.

District health boards bring together data from various sources, know the value and quality of the care they provide for older people in their district, and can easily learn from other DHBs.

Respectful end of life

Te mate rangatira i ngā tau whakamutunga o te hunga pakeke

This outcome area is about:

- respecting the goals and preferences of people in their last stages of life
- tailoring care to the physical, emotional, social and spiritual needs of the individual and their family and whānau
- continuing to provide high-quality palliative care and preparing the health system for future palliative care needs
- providing coordinated care that meets all individuals' needs, wherever they are
- supporting family and whānau and friends to support dying older people.



Why this is important

Death is a universal experience, and also a deeply personal one; our experience in the last stages of life can be profoundly important for us and those close to us.

This outcome area builds on the four others. At the end of life we continue to manage conditions, often in complex combinations requiring good coordination. A person in the last stages of their life can still be subject to episodes of acute illness and recovery, just as those in acute care can unexpectedly take a turn for the worse and require end of life care. The ultimate goal for the end of life is to achieve optimal wellbeing, physically, socially, emotionally and spiritually.

In the last stages of life, what commonly matters to people are: to feel accompanied by their family and whānau and friends, to be confident that their symptoms and pain are controlled well, attention to spiritual and cultural needs, and to receive good information, communication and well-coordinated care. We should expect, and take steps to ensure a person at the end of their life will receive high-quality palliative care that respects their wishes.

High-quality palliative care involves relieving the distressing symptoms and physical pain of a person with a life-threatening or terminal condition. It regards dying as a normal part of life, provides support for the person and

their family and whānau and friends helps them all come to terms with the dying process. It aims to be a positive influence on the course of illness, and to enable the person to live their regular day-to-day life as much as possible until their death. It seeks to give the person space to be themselves, achieve their goals and to interact with their family and whānau and friends as much or as little as they need.

We need to ensure that people at the last stages of their life are in control of their care as much as they are able, and that their preferences are well understood and adhered to as much as practical by those involved in their care.

New Zealanders hold many different world views; they have different cultural and spiritual needs and different expectations about the end of life as well as ideas about family, community and life in general. As a health system we should acknowledge and respect the diversity of our older population, and the profound emotional and spiritual significance of the end of life process.

Achieving a respectful end of life for Māori, Pacific and other ethnic communities requires all health practitioners and services and personnel to be particularly aware of the physical, mental, social and spiritual needs of individuals, their families and whānau. A good understanding of tikanga is also essential.

Increasing the emphasis on primary palliative care

As our population ages, more people will die each year. Many will have uncomplicated deaths, but as we live longer, we can expect increasing numbers of people with more complex conditions and comorbidities, including dementia, requiring more specialised care. As a health system, we will need to make sure we can consistently provide end of life care to a high standard and that we have the capacity to meet future demand. We need to embed palliative care as a core element of practice across the broader health workforce and ensure this workforce is adequately supported by a highly trained specialist workforce.

There are opportunities to use a range of professions better, including in pharmacy and allied health, to improve the quality of palliative care, for example, through medicine optimisation services. Pharmacists, physiotherapists, occupational therapists, speech and language therapists, dieticians, social workers and psychologists, practice nurses and others can be involved in ensuring wellbeing in the last stages of life.

If our primary health care workforce is trained in core palliative care practices, we should be able to continue to meet people's palliative care needs. However, it will require an adequate specialist palliative care workforce to provide specialist clinical care as well as support, advice and education. Shared

clinical records, patient portals and other technologies will support this integrated service delivery.

Improving quality in all settings

Palliative care takes place in a variety of settings, including in hospitals, aged residential care, hospices and individuals' homes. Ideally, it takes place where a person wants to be and where they feel safe, comfortable and supported. It is coordinated by a qualified individual or a multi-disciplinary team of the person's choosing.

Sometimes the onset of the last stages of life is quicker than expected, and a person can spend their last hours dying somewhere unanticipated. To ensure seamless care, we need to support, up-skill and use the existing skills and experience of staff across all health care settings to ensure they are adequately prepared to provide palliative care as needed.

As part of the work towards improving the quality of end-of-life care in all settings, we need to understand and measure the key indicators of good palliative care, including from an individual and whānau perspective. There needs to be national agreement on what constitutes quality end-of-life care, and we need to enforce quality standards that apply to all areas of the health system to ensure we provide consistently good palliative care.

Growing the capability of carers and communities

Families and whānau and carers can be intimately involved in the dying process and can make an invaluable contribution to the experience of the dying person. We need to support these carers well and recognise the importance of their role and the impact of caring for a dying person.

We can improve the support we provide informal carers, by providing respite, information, guidance, and training to lift their skills and confidence. We need to work with employers to ensure informal carers are respected in the workplace and to reduce any work-related barriers to their caregiving.

Responding to the voices of people with palliative care needs and their families and whānau

Clear communication is an essential factor to good quality end-of-life care. The health system must strive to ensure that a dying person's goals and wishes have been well articulated, understood and respected by all involved in their care at every levels.

Information on people's experiences, including bereaved people, is an invaluable tool for ensuring palliative

care is person-centred, and identifying areas for improvement.

We will take steps to accommodate people's wishes the best we can, and respond to what people, and their friends and family have told us in order to continually improve palliative care.

Goals for enabling a respectful end of life

- The health system responds to older people's goals and care needs at the end stages of life, and the experience of their family, whānau, caregivers and friends involved in their end-of-life care.
- All health care teams are responsive to the cultural needs of different groups.
- Health service providers coordinate palliative care to ensure all providers in the health system are used to their fullest. All of those who support people dying in old age are aware of the dying person's plans and know their own role in achieving those plans.
- People die feeling as comfortable and safe as possible.
- Expert advice and support is available to families and whānau, other carers and the health workforce involved in end-of-life care.

Turning the Strategy into action

Achieving the vision and goals set out in this strategy requires the commitment of many people across and throughout the health and social system, working in partnership with NGOs, communities, older people and their families and whānau.



It also requires us to have the right set of actions, and the right leadership and systems in place to implement those actions and keep us on course.

A package of actions is set out over the following pages to implement this strategy over a 10-year period.

The actions were developed in discussion with older people and their representatives as well as other stakeholders from the health and social system across New Zealand.

The actions are organised under the strategy's goals, so that they are appropriately outcome-oriented in accordance with a life-course approach. There are links and inter-dependencies across the actions and common themes that will mean that some of them will be developed and implemented together through cross- and intra-sectoral teams. These include:

- actions focused on vulnerable and high-needs older population groups
- actions focused on information, tools and resources and other enablers
- actions including referral pathways and other aspects of systems for integration, which would be linked for a system-wide approach to integration.

Equity and workforce are considered across all the actions.

Implementing the actions will involve a variety of stakeholders from across the health and social sectors, as well as older people and their families and whānau. Many of these partners are

listed alongside each action. However, each action is given a specific lead who takes on accountability for achieving that action.

Implementing the action plan

The action plan will be implemented in several phases. Actions that will be implemented over the first two years are shown with an asterisk (*). However, it is recognised that some of these actions will require longer than two years to fully implement.

The Ministry will develop an implementation plan with major partners, setting out the finer details of the actions, including the mechanism, timing, sequencing, responsibilities and resourcing required for each one.

Implementing these actions will rely on skilled leadership, solid partnerships and participation across the health and social systems. We need this strategy to represent a shared vision for the future, and we need to work together to achieve our aims.

A system of continuous improvement

The health system is, and operates in, a complex and dynamic environment within a highly networked system with multiple inter-dependencies. We are limited in our ability to predict the future, so we need to be mindful and flexible and ready to adapt in order to stay on track.

We recognise this Strategy is a living document. The Ministry will review the action plan after two years. The review will look at how well the actions are being delivered and how effective they are. We may need to adjust some actions, replace them or combine them with other initiatives to strengthen their chance of success. Implementation will always need to fit to the available resources, and we will need to prioritise the initiatives.

While the Ministry is responsible for putting together the Strategy and reporting on its progress, continuous improvements to health services and health outcomes for older people will require all relevant parties to remain involved and committed. This includes a wide variety of service providers, the

communities in which older people live and older people themselves.

We have a wealth of data and knowledge to inform our next steps, including through our investment in interRAI and research initiatives, such as the Ageing Well National Science Challenge (see: www.ageingwellchallenge.co.nz). In addition, the development of New Zealand's first health research strategy will help us build a more cohesive and effective health research and innovation system. We will harness these opportunities to ensure that we make the best use of current information and improve our understanding of healthy ageing.

Ultimately, we will ensure that information and our investment in, and the outcomes of, research inform policy development and service improvement.



Action plan

Ageing well goals

- Older people are physically, mentally and socially active; have healthy lifestyles and display greater resilience throughout their lives, meaning that they spend more of their lives in good health and living independently.
- Older people are health smart, able to make informed decisions about their health and know when and how to get help early.
- Everyone in the health system and in the wider social sector understands what contributes to healthy ageing and actively works to achieve it.
- All older populations in New Zealand are supported to age well in ways appropriate to their needs and cultures.
- Communities are age-friendly, with initiatives to keep people healthy, well-connected, independent, respected and able to participate fully in their communities and with family and whānau.

Actions	Lead Partners
1. Develop and support the growth of age-friendly communities.	
a. Promote the concept of age-friendly communities nationally and in communities and workforces.*	 Office for Seniors
b. Provide advice and tools to support older people, local government and others leading the establishment and development of age-friendly communities and builds the knowledge base for an age-friendly New Zealand.*	National, regional and local government agencies and NGOs, older people other community members
c. Build strong partnerships between DHBs, Healthy Families New Zealand, public health units, PHOs and age-friendly communities for effective healthy ageing initiatives in communities.*	

Actions	Lead Partners
<p>d. Develop, through a co-design process, a New Zealand-centric approach to age-friendly communities that:*</p> <ul style="list-style-type: none"> – draws from the WHO framework for age-friendly cities – builds on local experience – includes a networked infrastructure at national, regional and local levels. 	
2. Increase physical and mental resilience.	
<p>a. Increase the availability of strength and balance programmes in people’s homes and community settings.*</p>	<p>● ● ACC Health Quality & Safety Commission New Zealand, Ministry of Health, DHBs</p>
<p>b. Expand the provision of targeted health literacy initiatives, and services to increase resilience among Māori, Pacific and other priority older populations who have poorer health status.</p>	<p>● DHBs Government agencies</p>
<p>c. Review the Green Prescription programme, including the potential for other health professionals to prescribe and improve its utilisation by older people.</p>	<p>● Ministry of Health DHBs, primary health care</p>
<p>d. Increase understanding and explore partnerships in promoting mental health for older people at an individual, organisational and community level.</p>	<p>● Ministry of Health</p>
<p>e. Encourage services and providers to promote healthy eating, physical activity and healthy lifestyles.*</p>	<p>● ● DHBs health organisations, NGOs, New Zealand Nutritional Foundation</p>
<p>f. Encourage services and providers to promote the reduction of alcohol-related harm.*</p>	<p>Health Promotion Agency</p>

* Implemented in the first two years

● People powered ● Closer to home ● Value and high performance ● One team ● Smart system

Actions	Lead Partners
<p>3. Work across government on the socioeconomic determinants of health to prevent harm, illness and disability and improve people’s safety and independence.</p>	
<p>a. Work across government and social sector agencies to improve access, and coordinate assistance to socially isolated and other vulnerable older people and develop initiatives that better address the physical and social determinants of health.</p>	<p>● ● Ministry of Social Development, DHBs, other government agencies, PHOs, other NGOs</p>
<p>b. Participate in the cross-government Ministerial Group on Family Violence and Sexual Violence Work Programme.*</p>	<p>● ● ● Ministry of Social Development, Ministry of Justice</p>
<p>c. Update the <i>2007 Family Violence Intervention Guidelines: Elder Abuse and Neglect</i>, and promote their uptake by a wider range of health professionals.</p>	<p>● Ministry of Health</p>
<p>d. Establish a cross-government working group to identify and progress opportunities to improve housing options for older people and better enable older people to live in age- and disability-friendly homes.</p>	<p>● Ministry of Social Development Ministry of Business, Innovation & Employment Ministry of Health, Local Government New Zealand, Housing New Zealand</p>
<p>e. Support initiatives that maximise healthy ageing through supported housing and age-friendly communities where this will also contribute to regional economic and social development.*</p>	<p>● Ministry of Business, Innovation & Employment Te Puni Kōkiri, Ministry of Health</p>

Actions		Lead Partners
f. Promote volunteering, networking and paid work among older people, as a means to support their sense of wellbeing and social connection.	●	Ministry of Social Development NGOs, health providers
g. Increase the accessibility for older people of the built environment and transport services through the implementation of Priority 10(a) of the Disability Action Plan.	●	Ministry of Transport New Zealand Transport Agency

4. Improve health literacy.

a. Strengthen the capability of the workforce in provider organisations to understand the range of health literacy needs of older people, and improve the accessibility and responsiveness of services.	● ●	DHBs
b. Enhance health promotion and service information to Māori, Pacific peoples and other ethnic communities and priority groups to enable greater accessibility and engagement.	●	DHBs Primary health care
c. Improve the effectiveness of health literacy information distributed by health and social sector agencies.	●	Ministry of Health Health Promotion Agency
d. Support older people's uptake of technologies for communication with health providers and their family and whānau.*	●	DHBs Primary health care
e. Increase the accessibility of information on healthy ageing and health and social services through govt.nz, Your Health, SuperSeniors and links to other websites, so that people can be more 'health smart'.*	●	Ministry of Health Government agencies
f. Increase public and workforce awareness about and use of advance care planning and enduring powers of attorney across the health sector, government and community agencies and amongst older people and their carers.*	●	Ministry of Health Office for Seniors, Ministry of Social Development, community organisations

* Implemented in the first two years

● People powered ● Closer to home ● Value and high performance ● One team ● Smart system

Acute and restorative care goals

- Innovations and research support best practice triage, assessment, integrated care, discharge planning, rehabilitation strategies, and follow-up support
- Older people are supported through recovery by specialists and general staff who are competent to deal with common conditions, including frailty, delirium or dementia. Hospital staff and processes respect cultural preferences and differences
- Family, whānau and carers are included in discharge planning and receive training and support to provide ongoing rehabilitation in home and community settings
- Quality measures include patient experiences as well as clinical outcomes.

Actions	Lead Key partners
<p>5. Reduce inappropriate acute admissions and improve assessment processes.</p> <p>a. Support initiatives to reduce unnecessary acute admissions, for example by extending paramedic roles, improving after-hours clinical support for aged residential care facilities, using intensive home-based support, developing acute geriatric care pathways and applying proven technological solutions.*</p> <p>b. Work with the health sector to streamline acute assessment tools and processes and spread best practice options.*</p>	<p>DHBs</p> <p>Primary health care providers, emergency response services, aged residential care providers, needs assessment service providers, home and community support providers</p>

Actions	Lead Key partners
6. Improve treatment and outcomes for older people in hospital due to acute ill-health or injuries.	
a. Promote and implement evidence-based models of care to: – improve the patient journey and experience, including for those with delirium, dementia, and common frailty symptoms – improve the quality of care for those admitted for falls and fractures, including hip fractures – enhance early supported discharge planning – ensure patient experience and cultural responsiveness are reflected in quality measures.	● ACC Ministry of Health, Health Quality & Safety Commission New Zealand, DHBs
b. Make use of data to identify older people at risk of falls and fractures, to target and coordinate investments and interventions.	● ACC Ministry of Health, Health Quality & Safety Commission New Zealand, DHBs
7. Support effective rehabilitation closer to home by working across the whole system.	
a. Work with the sector (including service users) to identify and promote best practice in: – rehabilitation partnerships with primary health care, allied health, community nurses, pharmacists, aged care providers, home support providers, family and whānau – home-based and community-based models that support ongoing rehabilitation and restoration of older people – facilitating staff working in rehabilitation to collaborate across workforce groups and work to the top of their scope.	● Ministry of Health DHBs, primary care providers, aged-residential care, home support providers, older people, and carers

* Implemented in the first two years

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Living well with long-term conditions goals

- Improved methods of early detection and prevention result in fewer older people being affected by long-term conditions or frailty.
- Older people with long-term conditions retain the highest level of mental and physical function possible; they enjoy life, and their communities respect them.
- Older people with long-term conditions are ‘health smart’, are actively self-managing their conditions to a practical and comfortable level and are supported to do so closer to home.
- The workforces that support older people with long-term conditions, including the health workforce, home and community support services and family and whānau carers, have appropriate resources, structures and training.
- Home and community support services are equitable and appropriate to older people’s needs and preferences and maximise their wellbeing.
- Health outcomes for vulnerable older populations with long-term conditions are equitable, with good outcomes for the population as a whole.

Actions	Lead Key partners
<p>8. Improve models of care for home and community support services.</p> <p>a. Identify and implement models of care that are person-centred, needs-based and equitable, and deliver high-value, high-quality and better outcomes through home and community support services across New Zealand. As part of this work:*</p> <ul style="list-style-type: none"> – involve service users and their family and whānau – review the role of needs assessment and service coordination – ensure needs assessment and care planning are culturally appropriate and meet the needs of Māori and other priority population groups. <p>b. Use interRAI assessment data to identify quality indicators and service development opportunities including with health providers.*</p>	<p>Ministry of Health DHBs, aged-care providers</p> <p>● ●</p> <p>●</p> <p>Ministry of Health DHBs, aged care providers</p>

Actions	Lead Key partners
<p>9. Ensure that those working with older people with long-term conditions have the training and support they require to deliver high-quality, person-centred care in line with a healthy ageing approach.</p>	
<p>a. Regularise and improve training of the kaiāwhina workforce in home and community support services.*</p>	<p>● Ministry of Health DHBs, aged care providers</p>
<p>b. Ensure undergraduate and graduate curricula support an integrated model of care that:</p> <ul style="list-style-type: none"> – enables all health professionals to work as one team – works in partnership with older people and their family (including cultural understanding of older Māori) – promotes healthy ageing and restoration – addresses risk factors for social isolation and mental health and problematic alcohol use. 	<p>● ● ● Health Workforce New Zealand Tertiary training providers</p>
<p>c. Progress training packages to enhance the capacity and capability of kaiāwhina to support people with long-term conditions and their families and whānau, as part of the <i>Kaiāwahina Workforce Action Plan</i>.*</p>	<p>● ● Careerforce Health Workforce New Zealand</p>
<p>d. Develop a range of strategies to improve recruitment and retention of those working in aged care, beginning with an update of the 2011 report <i>Workforce for the care of older people</i> and development of a whole of workforce action plan.*</p>	<p>● Ministry of Health DHBs, aged care providers</p>
<p>e. Better utilise the allied health workforce to enhance care for older people in primary health care, home care and aged residential care.</p>	<p>● DHBs Primary health care, aged care providers</p>
<p>f. Enhance workforce capability and training pathways to encourage more entry and retention of the workforce among Māori and Pacific peoples and other ethnic groups.*</p>	<p>● ● Ministry of Health</p>
<p>g. Improve training and information for family carers that helps them to safely and competently carry out their caring role and keep well themselves.</p>	<p>● Ministry of Health</p>

* Implemented in the first two years

● People powered ● Closer to home ● Value and high performance ● One team ● Smart system

Actions	Lead Key partners
10. Enhance cross-sector, whole-of-system ways of working.	
a. Make better use of common points of contact across the health and social sectors to identify and support older people with mental health and alcohol and other drug problems earlier.	● ● Ministry of Health Ministry of Social Development, DHBs, housing agencies
b. Share educational resources and good practice on effective ways to increase physical activity levels among older people with debilitating health conditions to support service improvement.	● ● Providers
c. As part of implementing the <i>Pharmacy Action Plan 2016 to 2020</i> (Ministry of Health 2016), improve medicines management and encourage better liaison between pharmacists and other health professionals including through:	DHBs
– increasing use of brief interventions, screening, assessment and referral in primary health care, including by pharmacists	●
– sharing examples of innovative models of care that can be adopted to support pharmacist and pharmacist prescribers' delivery of medicines management.	●
11. Expand and strengthen the delivery of services to tackle long-term conditions.	
a. Strengthen the implementation of the New Zealand Dementia Framework, and the actions specified in <i>Improving the Lives of People with Dementia</i> (Ministry of Health 2014).*	● DHBs
b. Work with health and social services and communities to become more dementia-friendly.*	● Ministry of Health Office for Seniors, DHBs, Alzheimers New Zealand, Dementia Cooperative and other dementia organisations

Actions		Lead Key partners
c. Reduce the instances of complications from diabetes, particularly for people in aged residential care in line with <i>Living Well with Diabetes: A plan for people at high risk of or living with diabetes 2015–2020</i> (Ministry of Health 2015a), by providing tools, resources and quality standards.*	●	DHBs Primary health care, aged care providers
d. Better coordinate and integrate rehabilitation for people recovering from a stroke by identifying improvements to business models, the workforce and models of care.*	●	DHBs Ministry of Health, aged care providers
e. Provide community-based, early intervention programmes for people with musculoskeletal health conditions, including through the Mobility Action Programme.*	● ●	DHBs Ministry of Health, primary health care
f. Improve the early identification of mental illness and other conditions and addictions, such as problematic alcohol use, that can mask or contribute to other long-term conditions.	●	Primary health care DHBs
g. Ensure that older people with mild to moderate mental health conditions are able to access mental health services in their communities.		Primary health care DHBs

12. Better enable individuals and communities to understand and live well with long-term conditions and get the help they need to stay well.

a. Promote community support for older people with mental illness and substance misuse issues, to both reduce the stigma among older people and help them seek treatment.*	● ●	Primary health care DHBs
b. Ensure home and community support models of care cover advice to and support for older people to remain physically and mentally active, and strengthen skills they may have lost.	● ●	DHBs
c. Investigate options for rehabilitation services to support older people with low vision.*	● ●	Ministry of Health

* Implemented in the first two years

● People powered ● Closer to home ● Value and high performance ● One team ● Smart system

Actions	Lead Key partners
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13. Use new technologies to assist older people to live well with long-term conditions.

- | | | |
|--|-------|------------------------------------|
| a. Include health apps targeting older people with long-term conditions in the health app library that is currently being developed.* | ● ● ● | Ministry of Health |
| b. Promote use of technology options to monitor conditions and alleviate social isolation, especially among rural and remote locations.* | ● ● ● | DHBs
Primary health care |
| c. Promote the use of assistive technologies to support home-care workers to achieve good outcomes. | ● ● | DHBs |

14. Improve oral health in all community and service settings.

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|--|-----|--|
| a. Develop clinical pathways for optimal dental care throughout ageing and into the end of life, to maintain independence and minimise pain. | ● | Ministry of Health |
| | | DHBs, PHOs, oral health service providers |
| b. Identify and promote innovative care arrangements for the oral health care of older people receiving home and community support services and living in aged residential care. | ● ● | Ministry of Health |
| | | DHBs, PHOs, oral health service providers, aged care providers |
| c. Disseminate updated information and advice on dental care to older people’s families and carers, and aged-care providers.* | ● ● | Ministry of Health |
| | | DHBs, PHOs, oral health service providers, aged care providers |

* Implemented in the first two years

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Support for people with high and complex needs goals

- Older people with high and complex needs:
 - are able to live as independently and actively as possible
 - have the information and freedom to make good choices about the care and support they receive
 - know that health care workers understand their wishes and support their needs
 - are assured that information about their circumstances and needs flows easily between health care workers, in an integrated manner
 - have care plans that reduce the likelihood they will deteriorate markedly after a health event
 - are able to access care and support irrespective of their financial position
 - experience equitable access to services and equitable outcomes regardless of ethnicity or location
 - move easily to and through care settings that best meet their needs
 - have reduced need for acute care.
- Families, and whānau and carers have the support, information and training they need to help the older people they care for, and the stress of caring does not affect their own health.
- District health boards bring together data from various sources, know the value and quality of the care they provide for older people in their district and can easily learn from other DHBs.

Actions	Lead Key partners
15. Focused care of frailty in the community.	
a. Explore the possibilities for a frailty identification tool to enable primary and other health professionals to identify frail older people earlier.*	● ● Primary health care DHBs
b. Build responsiveness to frailty in primary health care settings and improve links to all necessary supports, treatment and rehabilitation services.	● Primary health care DHBs

* Implemented in the first two years

● People powered ● Closer to home ● Value and high performance ● One team ● Smart system

Actions	Lead Key partners
<p>16. With service users, their families and whānau, review the quality of home and community support services and aged residential care in supporting people with high and complex needs and involving family and other caregivers.</p>	
<p>a. Review the quality of home and community support and aged residential care in supporting older people with high and complex needs with service users and promote service commissioning models that enable such people to receive the care most suited to their needs, without unnecessary barriers to moving between care settings or deciding funding sources.</p>	<p>● ● DHBs Ministry of Health, ACC, NZ Aged Care Association, aged care providers</p>
<p>17. Integrate funding and service delivery around the needs and aspirations of older people to improve the health outcomes for priority population groups.</p>	
<p>a. In specific locations, trial commissioning one organisation to coordinate the health and support services for frail elderly people that:</p> <ul style="list-style-type: none"> – are strongly person centred and take account of family and whānau carer needs – assist older people to meet their individual objectives – minimise the need for the most expensive health and support services – could include primary health care, pharmacy, ambulance, home and community support, aged residential care and acute care services. 	<p>● DHBs Ministry of Health, service providers</p>
<p>b. Ensure that some trials focus on population groups that currently have poorer health and social outcomes or are not well catered for in current approaches.</p>	<p>● DHBs Ministry of Health, service providers</p>
<p>c. Develop referral systems for older people at risk of or experiencing social and economic isolation through their contact with primary care, aged-care needs assessors, social housing, the ACC and other government agencies.</p>	<p>● ● DHBs Government agencies, NGOs</p>
<p>d. Improve the coordination of health and social services to vulnerable older people within health and across the social sector.</p>	<p>● DHBs Government agencies</p>

Actions	Lead Key partners
18. Improve the physical and mental health outcomes of older people with long-term mental illness and addiction.	
a. Improve access to physical health services among people with high mental health and addiction needs, and improve integration of these services with residential care or home care services.	 DHBs Specialist AOD and Mental Health Services, primary health care, Ministry of Health, NZ Aged Care Association, aged care providers
19. Better integrate services for people living in aged residential care.	
a. Develop standard referral and discharge protocols between aged residential care facilities, pharmacists, primary care (including providers of after-hours services and medicines advice), ambulance and hospital services.*	 DHBs NZ Aged Care Association and aged residential care providers, pharmacists, primary care, ambulance
b. Explore technology options for providing advice and triage for aged residential care facilities, especially after hours.	 Ministry of Health
c. Ensure systems, resources and training are in place that allow aged residential care facilities to communicate with and involve family and whānau at the point of discharge from hospital or where urgent care is needed.	 Aged residential care providers DHBs, Ministry of Health
d. Explore options for aged residential care facilities to become providers of a wider range of services for older people such as post-acute restorative care, including non-residents.	 DHBs NZ Aged Care Association, Ministry of Health

* Implemented in the first two years

 People powered
 Closer to home
 Value and high performance
 One team
 Smart system

Actions	Lead Key partners
<p>20. Improve integration of information from assessment and care planning with acute care services, and with those responsible for advance care planning.</p>	
<p>a. Develop systems that collate relevant information and make it readily available at the point of care, as well as for planning at all levels.</p>	<ul style="list-style-type: none"> ● Ministry of Health DHBs, primary health care, pharmacists, aged residential care providers, home and community support providers
<p>b. Develop tools and resources for health professionals and providers to support the integration of long-term care management, acute care services and advance care planning.</p>	<ul style="list-style-type: none"> ● ● DHBs Service providers
<p>c. Ensure home and community support staff and, where appropriate, social workers and a range of health professionals, are able to contribute to shared care plans and interdisciplinary teams.</p>	<ul style="list-style-type: none"> ● Primary health care DHBs, Ministry of Health, home and community support providers
<p>21. Improve medicines management.</p>	
<p>a. Develop education partnerships between pharmacists and other health professionals to increase medication adherence and make better use of pharmacists' expertise.</p>	<ul style="list-style-type: none"> ● DHBs Pharmacists, primary health care, home and community support providers, aged residential care providers
<p>b. Implement pharmacist-led medicines reviews for older people with high needs receiving home and community support services and those in aged residential care.</p>	<ul style="list-style-type: none"> ● ● ● Primary health care Pharmacists, Home Support providers, aged residential care providers, DHBs

Actions	Lead Key partners
c. Ensure models of care and contractual arrangements provide equitable access to medicines management services targeting people receiving high-risk medicines and/or polypharmacy, people in aged residential care and older people with complex health needs living in their own homes.*	● DHBs Pharmacists, primary health care, home and community support providers, aged residential care providers

22. Build the resilience and capability of family and whānau, volunteer groups and other community groups that support older people with high and complex needs and those with end-of-life care needs.

a. Improve the support for informal carers in alignment with the <i>Caring for Carers: New Zealand Carers' Strategy Action Plan for 2014–2018</i> , including for various types of respite care, guidance and information, and training.	● Ministry of Social Development Ministry of Health, Ministry of Business, Innovation & Employment, ACC
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* Implemented in the first two years

● People powered ● Closer to home ● Value and high performance ● One team ● Smart system

Respectful end of life goals

- The health system responds to older people’s goals and care needs at the end stages of life and to the needs of their families, whānau, caregivers and friends involved in their end-of-life care.
- All health care teams are responsive to the cultural needs of different groups.
- Health service providers coordinate palliative care to ensure all providers in the health system are used to their fullest. All of those who support people dying in old age are aware of the dying person’s plans and know their own role in achieving those plans.
- People die feeling as comfortable and safe as possible.
- Expert advice and support is available to families and whānau, other carers and the health workforce involved in end-of-life care.

Actions	Lead Key partners
23. Build a greater palliative care workforce closer to home.	
a. Ensure that core elements of end-of-life care (such as aligning treatment with a patient’s goals, basic symptom management and psychosocial support) are an integral part of standard practice for all relevant health professionals and health care workers.	<ul style="list-style-type: none"> ● Ministry of Health Tertiary education providers, aged care providers, other health providers
b. Revise national referral guidance for specialist palliative care to better support sector understanding of the interface between specialist and primary palliative care.	<ul style="list-style-type: none"> ● Ministry of Health DHBs
c. Better utilise pharmacists, allied health and advanced nursing roles, and specialist palliative care nurses as members of integrated palliative care teams.	<ul style="list-style-type: none"> ● Ministry of Health, DHBs, PHOs
d. Encourage the use of new technologies to both support people at the ends of their lives to remain in their homes and enable easy access to shared clinical records and specialised support and advice, such as telecare, e-monitoring and assistance technologies in the home.	<ul style="list-style-type: none"> ● Ministry of Health, DHBs

Actions	Lead Key partners
24. Improve the quality and effectiveness of palliative care.	
a. Work with the Palliative Care Advisory Panel to implement the actions from the 2016 Review of Adult Palliative Care Services.*	● Ministry of Health
b. Develop and agree national service expectations and an outcomes framework for palliative care.	● Ministry of Health DHBs
c. Support the implementation of <i>Te Ara Whakapiri: Principles and guidance for the last days of life</i> (Ministry of Health 2015b).*	● Ministry of Health DHBs
d. Progress options for a national survey of patient and family and whānau carers' experiences of the care provided at the end of life to ensure person centred care.*	● ● Ministry of Health Health, Quality & Safety Commission New Zealand

* Implemented in the first two years

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Implementation, measurement and review

Actions		Lead Key partners
<p>25. Implement the Healthy Ageing Strategy.</p> <p>a. With health and social sector partners, complete a Healthy Ageing Strategy Implementation Plan within the first four months of the Strategy's release.*</p>		<p>Ministry of Health Wide range of partners</p>
<p>26. Include older people in service design, development and review and other decision-making processes.</p> <p>a. Work with older people to identify outcomes they wish to achieve from the services they receive and indicators of these desired outcomes when services are being designed or reviewed.</p> <p>b. Ensure there are feedback loops through which PHOs, DHBs and the wider health system can learn from outcomes, including patient experience, and plan for service and workforce improvement.</p> <p>c. Improve the knowledge of user's experience in home and community support and in aged residential care for service commissioning and monitoring outcomes.*</p> <p>d. Include representatives of older people in DHB forums.*</p> <p>e. As part of implementing the <i>Pharmacy Action Plan 2016 to 2020</i> (Ministry of Health 2016), co-design a service model with consumers to support the development and implementation of a minor ailments and referral service.*</p>		<p>DHBs</p> <p>DHBs Primary health care, ACC</p> <p>Health Quality & Safety Commission New Zealand Ministry of Health DHBs</p> <p>DHBs</p> <p>Ministry of Health Pharmacists DHBs</p>
<p>27. Establish an outcomes and measurement framework, commissioning and review processes.</p> <p>a. Develop a system to evaluate progress against the goals of the Healthy Ageing Strategy and support the health system to be person centred and focused on maximising healthy ageing and independence.*</p>		<p>Ministry of Health</p>

Actions		Lead Key partners
b. As part of the measurement and evaluation system, include an outcomes framework and indicators to assess, support and improve the health outcomes for older people (including where possible relevant measures that are already being produced for other purposes, such as for the Whānau Ora Outcomes Framework). These indicators will form contributory measures that district alliances can monitor to help them improve on the overall health system level measures.*	●	Ministry of Health DHBs, health providers, organisations representing older people
c. Regularly review the Healthy Ageing Strategy implementation progress and the prioritisation of actions.*	●	Ministry of Health DHBs
d. Publish indicators for each DHB on a regular basis.*	●	Ministry of Health DHBs
e. Develop strategies for lifting performance on indicators including researching the reasons for trends and the reasons for differences from better performing DHBs.	●	DHBs researchers, Ministry of Health
f. As part of implementing Health Strategy 2016 action 17(c)(iii), improve commissioning models for older people's services to enable streamlined and flexible contracting that supports providers to be sustainable.	●	Ministry of Health NGOs

28. Improve the knowledge base.

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| a. Implement a system to collect a minimum dataset on kaiāwhina workforce. | ● | Health Workforce New Zealand |
| b. Encourage National Science Challenges to appropriately communicate research relating to older people to a broad audience and encourage stakeholders to use the research to inform policy development and service design.* | ● | Ministry of Business, Innovation & Employment |
| c. Ensure alignment between the New Zealand Health Research Strategy, key research initiatives and centres with the identified needs of the ageing population, and that the research informs policy and service and workforce development.* | ● | Ministry of Health |

* Implemented in the first two years

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